

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard

City or town Daniels
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Daniels
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lawshe M Farley

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Elizabeth B. Farley

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1862 8.(c) If alive, give age _____ years

8. AGE: Years 86 Months 7 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace Penna
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business _____

12. Name Unknown

13. Birthplace "

14. Maiden name "

15. Birthplace "

16. Informant James Farley

Address Daniels Md

17. Burial Date thereof Oct 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Good Shepherd

Location Ellicott City Md

18. Funeral director F.C. Higinbotham

Address Ellicott City Md.

19. Oct 27, 1948 John P. Loughan
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948 at 4:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Sept 1948 to 26 Oct. 1948
and that I last saw him alive on 25 Oct. 1948

Immediate cause of death Submassive Infarct DURATION 2 days

Due to Cardiac Failure 4 days

Due to Arteriosclerotic Cardio-Vascular Disease 5 years

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William F. Jassawg M.D. M. D. or other _____

Address Ellicott City, Md Date signed 10-26-48

10552

93d

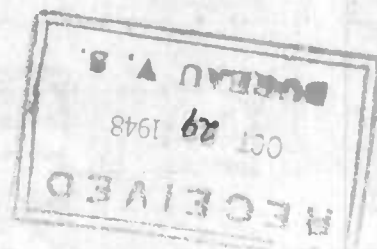
MARGIN RESERVED FOR BINDING

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9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10553
190

1. PLACE OF DEATH:

County HowardCity or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 46 yrs

Hospital, institution, or street address where death occurred:

5719 old Washington BlvdHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HowardCity or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 5719 old Washington Blvd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eleanor Randolph Lilly

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Robert H. Lilly6. (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.)

Nov 21 1877

8. AGE:

Years

70

Months

11

Days

6

If less than one day

hrs. min.

9. Birthplace

Front Royal Va
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

House wife

FATHER

12. Name

John Trean

13. Birthplace

Virginia

MOTHER

14. Maiden name

Christie Brown

15. Birthplace

Virginia

16. Informant

Mr Robert H. Lilly (House)

Address

5719 old Wash Blvd Elkridge, Md

17. (Burial, cremation, or removal. Which?)

Burial Date thereof Oct 29 1948
(month) (day) (year)

Cemetery or crematory

Meadowridge Memorial Park

Location

Elkridge Md

18. Funeral director

S. Lester Corp

Address

5543 main street Elkridge (27) Md

19. (Date rec'd by registrar)

Oct 27 48 (Miss) E. Bird Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948 at 12:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1948 to Oct 27 1948and that I last saw her alive on Oct 26 1948

Immediate cause of death

Chronic Pulmonary Tuberculosis

DURATION

18 mo

Due to

acute pulmonary hemorrhage5 min

Due to

hemorrhage2 1/2 hrsGeneral arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

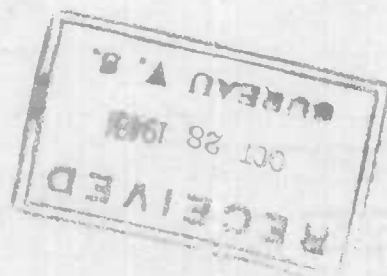
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

P. B. Brumbaugh
M. D. or otherAddress Elkridge Md Date signed 10/27/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10554

Reg. Dist. No. 194

1. PLACE OF DEATH:

County Howard
City or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Howard
City or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Charles David Pickett

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widower

8. (b) Name of husband or wife Katherine W Pickett
8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1859

8. AGE: Years 89 Months 2 Days 8 If less than one day hrs. min.

9. Birthplace Poplar Springs, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name John T. Pickett

13. Birthplace Md.

14. Maiden name Elizabeth Bowman

15. Birthplace Md.

16. Informant Mrs. Evans Ashmore
Address Clarksville, Md.

17. Burial Date thereof Oct. 31, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Poplar Spring

Location Poplar Springs Md.

18. Funeral director F.C. Higinbotham

Address Ellicott City Md.

19. 10-21 48 Marie G. Whitaker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 48 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 19 48, to Oct 28 19 48
and that I last saw him alive on October 28 19 48

Immediate cause of death acute cardiac failure DURATION 2 days

Due to arteriosclerotic heart disease } 10 yrs

Due to generalized arteriosclerosis } 30 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, publc place (where?)

Means of injury Injured at work?

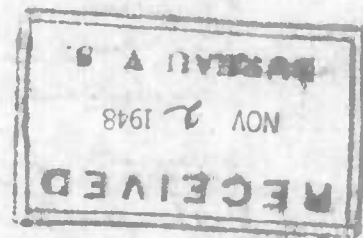
23. SIGNATURE Charles S. Whitaker, M.D.

Address Clarksville, Md. Date signed 10/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:

County Howard

City or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Howard Frederick Scott

3. (b) Social Security Number

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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6. (b) Name of husband or wife Florence Stevens Scott

7. Birth date of deceased (mo., day, yr.) June 22, 1877

6. (c) If alive, give age years

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>3</u>	<u>15</u> hrs. min.

9. Birthplace Clarksville Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Edmund C. Scott

13. Birthplace Md

14. Maiden name Emily Gambrill

15. Birthplace Md

16. Informant Mrs. H.F. Scott

Address Clarksville Md

17. Burial Date thereof 10-10-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Highland Md

18. Funeral director F.C. Higinbotham

Address Ellicott City Md.

19. Oct 11 19 48 Mario A. Whitaker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 19 48 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 19 46 to October 7 19 48
and that I last saw him alive on October 6 19 48

Immediate cause of death Coronary occlusion

DURATION 2 mins

Due to Coronary sclerosis

1 year

Due to Generalized arteriosclerosis 10 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D.
Clarksville, Md. M. D. or other 10-11-48
Address Date signed

10555

9400

194

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH: HOWARD
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
BALTO - WASH. BLVD.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 35 A STREET
(If rural, give LOCATION)
2(a) if veteran, name war.....

3. (a) FULL NAME
HENRY HARRISON SEALOCK

3. (b) Social Security Number
218 -12- 7961

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife MARY GRACE SEALOCK

7. Birth date of deceased (mo., day, yr) SEPT. 21, 1921 6. (c) If alive, give age..... years

8. AGE: Years 27 Months 1 Days 2 If less than one day..... hrs. min.

9. Birthplace FRONT ROYAL, VA.
(Town, county, and state)

10. Usual occupation CAB DRIVER

11. Industry or business Transportation

12. Name ANDREW SEALOCK

13. Birthplace VIRGINIA

14. Maiden name STELLA WILLIS

15. Birthplace VIRGINIA

16. Informant ANDREW SEALOCK

Address 35 A STREET, LAUREL, MD

17. (Burial, cremation, or removal. Which?) BURIAL Date thereof OCT. 27, 1948
(month) (day) (year)

Cemetery or crematory IVY HILL CEM.

Location LAUREL, MD

18. Funeral director Arthur H. Halls

Address 505 Washington Blvd., Laurel, Md.
10/25/48 Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH October 23 19 48 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 19 48 to Oct 23 19 48

and that I last saw him alive on at no time 19 48

Immediate cause of death..... DURATION

Compmin fracture Inst.

Due to road

Due to Auto accident

Other conditions fracture of left

bone
(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following: 10 23 48
Accident, suicide, or homicide accident Date of 10 23 48

Where did injury occur near Laurel Howard Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of Injury auto accident Injured at work? yes

23. SIGNATURE Alpha N. Herbert MD

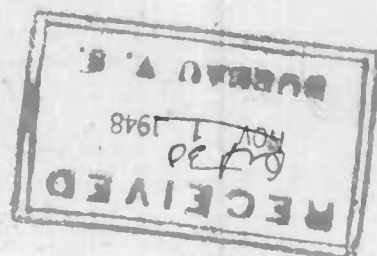
Address Ellicott City Md Date signed 10 24 48

MARGIN RESERVED FOR BINDING

VS-A15 9.45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:

County HowardCity or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Dorothy K Simpson

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Wm Cissel Simpson7. Birth date of deceased (mo., day, yr.) May 29, 1897

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
51 4 2 hrs. min.9. Birthplace Riverdale Md
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Charles Kerfoot13. Birthplace Va14. Maiden name Lola R. Stone15. Birthplace Washington D.C.16. Informant Mr. William Cissel SimpsonAddress Clarksville Md17. Burial Date thereof 10/1/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt ZionLocation Clarksville Md18. Funeral director F.C. HiginbothamAddress Ellicott City Md19. Oct 3 19 48 Maria A. Whittaker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/48 at 12 noon21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/1/48 to 10/1/48 and that I last saw him alive on 9/30/48Immediate cause of death Carcinomatosis
Carcinoma of Rt BreastDue to Carcinoma of Rt Breast

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D.Address Sandy Spring Md Date signed 10/1/48

